COMPARISON OF CURRENT LONG TERM CARE SYSTEM AND COMMUNITYCHOICE PROPOSAL
December 21, 2004

ISSUE	CURRENT SYSTEM	COMMUNITYCHOICE PROPOSAL
Eligibility		
Expand Medicaid eligibility/ Increase number of home and community based services (HCBS) waiver slots	• Eligibility is limited according to an individual's financial and medical status. • HCBS waiver slots are capped for both low-income (incomes below 100% of SSI) and higher-income (incomes between 100% and 300% of SSI) community beneficiaries. • Funds not available to expand Medicaid eligibility to higher income individuals or to increase the number of HCBS waiver slots.	• Medical eligibility criteria will not change. • Low-income, community beneficiaries who meet nursing facility level of care will no longer have to apply for a HCBS waiver slot to receive home-and community-based services; they will automatically become eligible through their CCO. • Higher-income, community beneficiaries will continue to apply for a HCBS waiver slot in order to receive Medicaid and HCBS. • A capped number of HCBS waiver slots continue to exist for higher income beneficiaries. • Future savings could be used to expand eligibility.
Nursing facility transition cases	• Higher-income (incomes above 300% of SSI) Medicaid recipients in nursing facilities become ineligible for Medicaid services if they are transitioned to the community.	• As part of the federal waiver application, we are requesting that when a higher-income beneficiary transitions out of a nursing home he/she can gain access to home and community services and maintain Medicaid eligibility by continuing to contribute to their cost-of-care.
Cost neutrality test for community services	• Beneficiaries who meet a nursing facility level of care can receive services in the community if the cost of community services is equal to or less than the **average** cost of nursing facility care.	• Beneficiaries who meet a nursing facility level of care can receive services in the community if the cost of community services is equal to or less than the **individual** cost of nursing facility care for that person. This is a fairer assessment of cost neutrality and may help beneficiaries who have higher than average costs.
Benefits		
"HCBS waiver-type" augmented community support services	• Available to the capped number of beneficiaries on the HCBS waivers, and beneficiaries transitioning from nursing facilities to the community.	• Available to more beneficiaries (all community Medicaid eligible individuals who meet nursing facility level of care and the individual cost neutrality test). Current community Medicaid eligible beneficiaries who are nursing facility level of care will have access to these benefits without needing a waiver slot. (Approximately 2,400 community Medicaid eligible beneficiaries are waiting to receive community services through either the Living at Home or Older Adults Waivers; 80% of whom are estimated to meet the nursing facility level of care requirements to receive community services.)

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Consumer-directed personal care	• Consumer direction is available only to the capped number of beneficiaries on one HCBS waiver (approximately 400 beneficiaries under the Living-At-Home Waiver). • Consumer-direction allows enrollees to: – Direct the development of their care plan; –Hire, train, and supervise their personal care workers; and, –Waive provider credentialing standards. • Only beneficiaries on a HCBS waiver can select a family member (except a spouse) to be their provider.	• Available to any CommunityChoice enrollee who needs personal care services and wants to direct his/her care. There are currently approximately 5,400 beneficiaries receiving personal care services in the long-term care system. • Consumer-directed option still allows enrollees to: – Direct the development of their care plan; – Hire, train, and supervise their personal care workers; and, – Waive provider credentialing standards. • Consumer-directed option adds two new features: – Negotiate payment rates with personal care provider; and – Establish an individualized budget to meet personal care needs. • Any CommunityChoice enrollee who needs personal care services can choose to hire a family member (except spouses).
Care coordinator	• Available to a limited population (approximately 3,200 beneficiaries on the HCBS waivers receive case managers)	• Available to more beneficiaries (all enrollees meeting a nursing facility or chronic hospital level of care, enrollees receiving personal care services, and enrollees with serious and persistent mental illness.) For approximately one-third to one-half of the 75,000 CommunityChoice enrollees, CCOs will be required to provide care coordinators.
Medicare and Medicaid coordination	• For dual eligibles, Medicare is the primary payer. • Medicare and Medicaid services are not coordinated.	• For dual eligibles, Medicare continues to be the primary payer. • Greater coordination of Medicare and Medicaid services, which promotes better quality of care, reduces cost shifting, and makes the system simpler for participants. • CCOs will be Medicare Advantage plans. • Participants can **choose** to enroll in a Medicare Advantage plan and receive all Medicaid and Medicare services from one organization.
Mental health	• For dual eligibles, Medicare is the primary payer. • Lack of coordination of 1) Medicare and Medicaid mental health services, and 2) mental health and physical health services. • All mental health services are covered through the Public Mental Health System	• For dual eligibles, Medicare continues to be the primary payer. • Coordination of Medicare and Medicaid mental health services will increase. • Mental health and physical health services are covered by CCOs, increasing coordination. • Psychiatric rehabilitation services will be provided through the Public Mental Health System, outside CCOs

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Medicare drug coverage	• For dual eligibles, prescription drugs will be covered by Medicare beginning in January 2006.	• Does not change.
Housing	• Lack of housing can act as a barrier to staying in/returning to the community.	• Lack of housing can act as a barrier to staying in/returning to the community. • With more community services available in the benefit package, beneficiaries can stay in their homes longer. • CCOs will have the flexibility to devote funds to housing, potentially enabling more people to receive services in the community.
Access and Quality		
Quality oversight	• Limited, fragmented quality oversight activities. • Focus is on meeting and maintaining quality standards.	• DHMH will implement a new comprehensive quality strategy. • Focus will not only be on meeting quality standards, but showing improvement over time. • CCOs must meet quality standards included in the application criteria prior to participating in CommunityChoice, and will be subject to quality reviews on an annual and ongoing basis. • DHMH will hire independent contractors to conduct some new quality activities (e.g., satisfaction surveys).
Role of OHCQ	• OHCQ is responsible for certain provider-level licensing and inspections. • OHCQ resources are currently stretched.	• Does not change. OHCQ will continue to certify smaller assisted living providers who want to participate in Medicaid. • The Department expects to reallocate some of the savings from CommunityChoice to OHCQ.
Access to appropriate level of care	• Beneficiaries can access medically necessary and appropriate services. Many times, however, they are left to navigate through the health care system by themselves, causing them to go without necessary services or to receive services in less-appropriate settings.	• Through better care coordination, CCOs will improve beneficiaries' access to medically necessary and appropriate services. • New network adequacy requirements will ensure access to appropriate levels of care, including higher levels of care.
Choice of providers and ability to change providers	• Beneficiaries have freedom of choice of providers.	• Beneficiaries still have freedom of choice of providers. • Beneficiaries will always have the choice of at least two CCOs. • Beneficiaries will have an annual right to change CCOs and will be able change CCOs at any time upon a showing good cause • Within a CCO, beneficiaries will have a choice of primary care providers (PCPs), and can change PCPs at any time.

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Choice of providers and ability to change providers (cont'd)		• Choice of nursing facilities stays the same. Beneficiaries needing nursing facilities can choose any Medicaid-participating nursing facility. • Choice of personal care providers increases. Beneficiaries needing personal care can choose family members (except spouses) as personal care aides or waive certain provider credentialing standards. • Choice of psychiatric rehabilitation providers stays the same. • Choice of Medicare providers stays the same. • Choice of hospice providers stays the same. • Individuals already receiving adult day care or assisted living services will not be forced to change providers, unless quality issues exist.
Choice of nursing homes	• Beneficiaries can choose any nursing facility that participates with Medicaid.	• Choice of nursing facilities stays the same. Beneficiaries needing nursing facilities can choose any Medicaid-participating nursing facility. No one needing nursing facility services will be forced out or kept out of a nursing facility. • DHMH will regulate reimbursement rates for nursing facility services based on the fee-for-service methodology. After the first year, nursing homes may choose to negotiate different payment rates.
Provider quality standards	• Providers must meet OHCQ and Medicaid licensure and credentialing standards.	• Providers must continue to meet OHCQ and Medicaid licensure and credentialing standards. • CCOs must follow State policies for credentialing and recredentialing of providers who have signed contracts with the CCO. • CCOs could introduce additional quality improvement standards for in-network providers. In this case, in-network providers would have to meet the CCOs' licensure and credentialing standards.
Availability of community based service providers	• Medicaid reimbursement rates for some community based service providers are low. There are no funds available to improve provider participation or to increase provider rates. Moreover, no money is available for offering new services.	• CCOs would have the flexibility to increase payments for providers to build provider capacity where needed. Under HealthChoice provider participation and rates have improved, for example for physicians. • CCOs also would have the flexibility to offer new programs and services, *e.g.*, outreach and educational programs.

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Availability of specialists	• There is short supply of some specialists in some rural areas. There are no funds available to improve provider participation or to increase provider rates.	• CCOs would have the flexibility to increase payments for providers to build provider capacity where needed. Under HealthChoice provider participation and rates have improved, for example for physicians.
Other		
Administrative structure	• Staff and resources are devoted to administering a fragmented, long-term care system.	• Staff and resources will need to increase and be redeployed to focus on quality oversight and new participant safeguards. For example, in CommunityChoice, we will have a central hotline for participants to call the State to voice complaints. The savings are expected to exceed the additional administrative costs. • CommunityChoice will streamline an already large bureaucracy and be held accountable for providing and coordinating quality services.
Participation of for-profit entities	• There are no provider restrictions based on tax status. • HealthChoice MCOs can be for-profit or non-profit. Currently all HealthChoice MCOs are for-profit. • Most long-term care providers (such as nursing homes) are for-profit.	• There will continue to be no provider restrictions based on tax status. • DHMH will set the minimum qualifications to become a CCO, which includes provider network standards, information technology infrastructure (e.g., claims payment systems), and financial solvency standards. Any organizations, regardless of their tax status, that meet these qualifications will be allowed to participate in CommunityChoice. • The Department will work with the Advisory Group to develop regulations that define a methodology to calculate medical loss ratio and targets.